STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155441	A. BUILDING _____ B. WING _____	R 10/02/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CORYDON NURSING AND REHABILITATION CENTER	**315 COUNTRY CLUB RD CORYDON, IN 47112**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
{F 000}	INITIAL COMMENTS	{F 000}		

This visit was for a Post Survey Visit (PSR) to the Recertification and State Licensure Survey completed on August 21, 2015.

Survey date: October 2, 2015

Facility number: 000338
Provider number: 155441
AIM number: 100287590

Census bed type:
SNF/NF: 27
Total: 27

Census payor type:
Medicare: 2
Medicaid: 19
Other: 6
Total: 27

Corydon Nursing and Rehabilitation Center was found to be in compliance with 42 CFR Part 483, Subpart B and 410 IAC 16.2-3.1, in regards to the PSR to the Recertification and State Licensure Survey.

Quality review completed by #02748 on October 6, 2015.

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE